105TH CONGRESS
1ST SESSION

S. 879

To provide for home and community-based services for individuals with disabilities, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 11, 1997

Mr. FEINGOLD introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To provide for home and community-based services for individuals with disabilities, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Long-Term Care Reform and Deficit Reduction Act of 1997''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DISABILITIES

Sec. 101. State programs for home and community-based services for individuals with disabilities.
Sec. 102. State plans.
Sec. 103. Individuals with disabilities defined.
Sec. 104. Home and community-based services covered under State plan.
Sec. 105. Cost sharing.
Sec. 106. Quality assurance and safeguards.
Sec. 107. Advisory groups.
Sec. 108. Payments to States.
Sec. 109. Appropriations; allotments to States.
Sec. 110. Federal evaluations.
Sec. 111. Information and technical assistance grants relating to development of hospital linkage programs.

TITLE II—PROSPECTIVE PAYMENT SYSTEM FOR NURSING FACILITIES

Sec. 201. Definitions.
Sec. 202. Payment objectives.
Sec. 203. Powers and duties of the Secretary.
Sec. 204. Relationship to title XVIII of the Social Security Act.
Sec. 205. Establishment of resident classification system.
Sec. 206. Cost centers for nursing facility payment.
Sec. 207. Resident assessment.
Sec. 208. The per diem rate for nursing service costs.
Sec. 209. The per diem rate for administrative and general costs.
Sec. 210. Payment for fee-for-service ancillary services.
Sec. 211. Reimbursement of selected ancillary services and other costs.
Sec. 212. Per diem payment for property costs.
Sec. 213. Mid-year rate adjustments.
Sec. 214. Exception to payment methods for new and low volume nursing facilities.
Sec. 215. Appeal procedures.
Sec. 216. Transition period.
Sec. 217. Effective date; inconsistent provisions.

TITLE III—ADDITIONAL MEDICARE PROVISIONS

Sec. 301. Elimination of formula-driven overpayments for certain outpatient hospital services.
Sec. 302. Permanent extension of certain secondary payer provisions.
Sec. 303. Financing and quality modernization and reform.

TITLE I—HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DISABILITIES

SEC. 101. STATE PROGRAMS FOR HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DISABILITIES.

(a) IN GENERAL.—Each State that has a plan for home and community-based services for individuals with disabilities submitted to and approved by the Secretary under section 102(b) may receive payment in accordance with section 108.

(b) ENTITLEMENT TO SERVICES.—Nothing in this title shall be construed to create a right to services for individuals or a requirement that a State with an approved plan expend the entire amount of funds to which it is entitled under this title.

(c) DESIGNATION OF AGENCY.—Not later than 6 months after the date of enactment of this Act, the Secretary shall designate an agency responsible for program administration under this title.

SEC. 102. STATE PLANS.

(a) PLAN REQUIREMENTS.—In order to be approved under subsection (b), a State plan for home and commu-

nity-based services for individuals with disabilities must meet the following requirements:

(1) STATE MAINTENANCE OF EFFORT.—

(A) IN GENERAL.—A State plan under this title shall provide that the State will, during any fiscal year that the State is furnishing services under this title, make expenditures of State funds in an amount equal to the State maintenance of effort amount for the year determined under subparagraph (B) for furnishing the services described in subparagraph (C) under the State plan under this title or under the State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(B) STATE MAINTENANCE OF EFFORT AMOUNT.—

(i) IN GENERAL.—The maintenance of effort amount for a State for a fiscal year is an amount equal to—

(I) for fiscal year 1999, the base amount for the State (as determined under clause (ii)) updated through the midpoint of fiscal year 1999 by the estimated percentage change in the index described in clause (iii) during

the period beginning on October 1, 1997, and ending at that midpoint; and

(II) for succeeding fiscal years, an amount equal to the amount determined under this clause for the previous fiscal year updated through the midpoint of the year by the estimated percentage change in the index described in clause (iii) during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous underestimations or overestimations under this clause in the projected percentage change in such index.

(ii) STATE BASE AMOUNT.—The base amount for a State is an amount equal to the total expenditures from State funds made under the State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) during fiscal year 1997 with respect to medical assistance consisting of the services described in subparagraph (C).

(iii) INDEX DESCRIBED.—For purposes of clause (i), the Secretary shall develop an index that reflects the projected increases in spending for services under subparagraph (C), adjusted for differences among the States.

(C) MEDICAID SERVICES DESCRIBED.—The services described in this subparagraph are the following:

(i) Personal care services (as described in section 1905(a)(24) of the Social Security Act (42 U.S.C. 1396d(a)(24))).

(ii) Home or community-based services furnished under a waiver granted under subsection (c), (d), or (e) of section 1915 of such Act (42 U.S.C. 1396n).

(iii) Home and community care furnished to functionally disabled elderly individuals under section 1929 of such Act (42 U.S.C. 1396t).

(iv) Community supported living arrangements services under section 1930 of such Act (42 U.S.C. 1396u).

(v) Services furnished in a hospital, nursing facility, intermediate care facility

for the mentally retarded, or other institutional setting specified by the Secretary.

(2) ELIGIBILITY.—

(A) IN GENERAL.—Within the amounts provided by the State and under section 108 for such plan, the plan shall provide that services under the plan will be available to individuals with disabilities (as defined in section 103(a)) in the State.

(B) INITIAL SCREENING.—The plan shall provide a process for the initial screening of an individual who appears to have some reasonable likelihood of being an individual with disabilities. Any such process shall require the provision of assistance to individuals who wish to apply but whose disability limits their ability to apply. The initial screening and the determination of disability (as defined under section 103(b)(1)) shall be conducted by a public agency.

(C) RESTRICTIONS.—

(i) IN GENERAL.—The plan may not limit the eligibility of individuals with disabilities based on—

(I) income;

(II) age;

(III) residential setting (other than with respect to an institutional setting, in accordance with clause (ii)); or

(IV) other grounds specified by the Secretary;

except that through fiscal year 2007, the Secretary may permit a State to limit eligibility based on level of disability or geography (if the State ensures a balance between urban and rural areas).

(ii) INSTITUTIONAL SETTING.—The plan may limit the eligibility of individuals with disabilities based on the definition of the term ''institutional setting'', as determined by the State.

(D) CONTINUATION OF SERVICES.—The plan must provide assurances that, in the case of an individual receiving medical assistance for home and community-based services under the State medicaid plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) as of the date a State's plan is approved under this title, the State will continue to make available

(either under this plan, under the State medicaid plan, or otherwise) to such individual an appropriate level of assistance for home and community-based services, taking into account the level of assistance provided as of such date and the individual's need for home and community-based services.

(3) SERVICES.—

(A) NEEDS ASSESSMENT.—Not later than the end of the second year of implementation, the plan or its amendments shall include the results of a statewide assessment of the needs of individuals with disabilities in a format required by the Secretary. The needs assessment shall include demographic data concerning the number of individuals within each category of disability described in this title, and the services available to meet the needs of such individuals.

(B) SPECIFICATION.—Consistent with section 104, the plan shall specify—

(i) the services made available under the plan;

(ii) the extent and manner in which such services are allocated and made available to individuals with disabilities; and

(iii) the manner in which services under the plan are coordinated with each other and with health and long-term care services available outside the plan for individuals with disabilities.

(C) TAKING INTO ACCOUNT INFORMAL CARE.—A State plan may take into account, in determining the amount and array of services made available to covered individuals with disabilities, the availability of informal care. Any individual plan of care developed under section 104(b)(1)(B) that includes informal care shall be required to verify the availability of such care.

(D) ALLOCATION.—The State plan—

(i) shall specify how services under the plan will be allocated among covered individuals with disabilities;

(ii) shall attempt to meet the needs of individuals with a variety of disabilities within the limits of available funding;

(iii) shall include services that assist all categories of individuals with disabilities, regardless of their age or the nature of their disabling conditions;

(iv) shall demonstrate that services are allocated equitably, in accordance with the needs assessment required under subparagraph (A); and

(v) shall ensure that—

(I) the proportion of the population of low-income individuals with disabilities in the State that represents individuals with disabilities who are provided home and community-based services either under the plan, under the State medicaid plan, or under both, is not less than

(II) the proportion of the population of the State that represents individuals who are low-income individuals.

(E) LIMITATION ON LICENSURE OR CERTIFICATION.—The State may not subject consumer-directed providers of personal assistance services to licensure, certification, or other requirements that the Secretary finds not to be necessary for the health and safety of individuals with disabilities.

(F) CONSUMER CHOICE.—To the extent feasible, the State shall follow the choice of an individual with disabilities (or that individual's designated representative who may be a family member) regarding which covered services to receive and the providers who will provide such services.

(4) COST SHARING.—The plan may impose cost sharing with respect to covered services in accordance with section 105.

(5) TYPES OF PROVIDERS AND REQUIREMENTS FOR PARTICIPATION.—The plan shall specify—

(A) the types of service providers eligible to participate in the program under the plan, which shall include consumer-directed providers of personal assistance services, except that the plan—

(i) may not limit benefits to services provided by registered nurses or licensed practical nurses; and

(ii) may not limit benefits to services provided by agencies or providers certified under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.); and

(B) any requirements for participation applicable to each type of service provider.

(6) PROVIDER REIMBURSEMENT.—

(A) PAYMENT METHODS.—The plan shall specify the payment methods to be used to reimburse providers for services furnished under the plan. Such methods may include retrospective reimbursement on a fee-for-service basis, prepayment on a capitation basis, payment by cash or vouchers to individuals with disabilities, or any combination of these methods. In the case of payment to consumer-directed providers of personal assistance services, including payment through the use of cash or vouchers, the plan shall specify how the plan will assure compliance with applicable employment tax and health care coverage provisions.

(B) PAYMENT RATES.—The plan shall specify the methods and criteria to be used to set payment rates for—

(i) agency administered services furnished under the plan; and

(ii) consumer-directed personal assistance services furnished under the plan, including cash payments or vouchers to indi-

viduals with disabilities, except that such payments shall be adequate to cover amounts required under applicable employment tax and health care coverage provisions.

(C) PLAN PAYMENT AS PAYMENT IN FULL.—The plan shall restrict payment under the plan for covered services to those providers that agree to accept the payment under the plan (at the rates established pursuant to subparagraph (B)) and any cost sharing permitted under section 105 as payment in full for services furnished under the plan.

(7) QUALITY ASSURANCE AND SAFEGUARDS.—The State plan shall provide for quality assurance and safeguards for applicants and beneficiaries in accordance with section 106.

(8) ADVISORY GROUP.—The State plan shall—

(A) assure the establishment and maintenance of an advisory group in accordance with section 107(b); and

(B) include the documentation prepared by the group under section 107(b)(4).

(9) ADMINISTRATION AND ACCESS.—

(A) STATE AGENCY.—The plan shall designate a State agency or agencies to administer (or to supervise the administration of) the plan.

(B) COORDINATION.—The plan shall specify how it will—

(i) coordinate services provided under the plan, including eligibility prescreening, service coordination, and referrals for individuals with disabilities who are ineligible for services under this title with the State medicaid plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), titles V and XX of such Act (42 U.S.C. 701 et seq. and 1397 et seq.), programs under the Older Americans Act of 1965 (42 U.S.C. 3001 et seq.), programs under the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6000 et seq.), programs under the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.), and any other Federal or State programs that provide services or assistance targeted to individuals with disabilities; and

(ii) coordinate with health plans.

(C) ADMINISTRATIVE EXPENDITURES.—Effective beginning with fiscal year 2007, the plan shall contain assurances that not more than 10 percent of expenditures under the plan for all quarters in any fiscal year shall be for administrative costs.

(D) INFORMATION AND ASSISTANCE.—The plan shall provide for a single point of access to apply for services under the State program for individuals with disabilities. Notwithstanding the preceding sentence, the plan may designate separate points of access to the State program for individuals under 22 years of age, for individuals 65 years of age or older, or for other appropriate classes of individuals.

(10) REPORTS AND INFORMATION TO SECRETARY; AUDITS.—The plan shall provide that the State will furnish to the Secretary—

(A) such reports, and will cooperate with such audits, as the Secretary determines are needed concerning the State's administration of its plan under this title, including the processing of claims under the plan; and

(B) such data and information as the Secretary may require in a uniform format as specified by the Secretary.

(11) USE OF STATE FUNDS FOR MATCHING.—The plan shall provide assurances that Federal funds will not be used to provide for the State share of expenditures under this title.

(12) HEALTH CARE WORKER REDEPLOYMENT.—The plan shall provide for the following:

(A) Before initiating the process of implementing the State program under such plan, negotiations will be commenced with labor unions representing the employees of the affected hospitals or other facilities.

(B) Negotiations under subparagraph (A) will address the following:

(i) The impact of the implementation of the program upon the workforce.

(ii) Methods to redeploy workers to positions in the proposed system, in the case of workers affected by the program.

(C) The plan will provide evidence that there has been compliance with subparagraphs (A) and (B), including a description of the results of the negotiations.

(13) TERMINOLOGY.—The plan shall adhere to uniform definitions of terms, as specified by the Secretary.

(b) APPROVAL OF PLANS.—The Secretary shall approve a plan submitted by a State if the Secretary determines that the plan—

(1) was developed by the State after a public comment period of not less than 30 days; and

(2) meets the requirements of subsection (a).

The approval of such a plan shall take effect as of the first day of the first fiscal year beginning after the date of such approval (except that any approval made before October 1, 1998, shall be effective as of such date). In order to budget funds allotted under this title, the Secretary shall establish a deadline for the submission of such a plan before the beginning of a fiscal year as a condition of its approval effective with that fiscal year. Any significant changes to the State plan shall be submitted to the Secretary in the form of plan amendments and shall be subject to approval by the Secretary.

(c) MONITORING.—The Secretary shall annually monitor the compliance of State plans with the requirements of this title according to specified performance standards. In accordance with section 108(e), States that fail to comply with such requirements may be subject to

a reduction in the Federal matching rates available to the State under section 108(a) or the withholding of Federal funds for services or administration until such time as compliance is achieved.

(d) TECHNICAL ASSISTANCE.—The Secretary shall ensure the availability of ongoing technical assistance to States under this section. Such assistance shall include serving as a clearinghouse for information regarding successful practices in providing long-term care services.

(e) REGULATIONS.—The Secretary shall issue such regulations as may be appropriate to carry out this title on a timely basis.

SEC. 103. INDIVIDUALS WITH DISABILITIES DEFINED.

(a) IN GENERAL.—For purposes of this title, the term ''individual with disabilities'' means any individual within 1 or more of the following categories:

(1) INDIVIDUALS REQUIRING HELP WITH ACTIVITIES OF DAILY LIVING.—An individual of any age who—

(A) requires hands-on or standby assistance, supervision, or cueing (as defined in regulations) to perform 3 or more activities of daily living (as defined in subsection (d)); and

(B) is expected to require such assistance, supervision, or cueing for a chronic condition that will last at least 180 days.

(2) INDIVIDUALS WHO REQUIRE SUPERVISION DUE TO COGNITIVE OR OTHER MENTAL IMPAIRMENTS.—An individual of any age—

(A) who requires supervision to protect himself or herself from threats to health or safety due to impaired judgment, or who requires supervision due to symptoms of 1 or more serious behavioral problems (that is on a list of such problems specified by the Secretary); and

(B) who is expected to require such supervision for a chronic condition that will last at least 180 days.

Not later than 2 years after the date of enactment of this Act, the Secretary shall make recommendations regarding the most appropriate duration of disability under this paragraph.

(3) INDIVIDUALS WITH SEVERE OR PROFOUND MENTAL RETARDATION.—An individual of any age who has severe or profound mental retardation (as determined according to a protocol specified by the Secretary).

(4) INDIVIDUALS WITH MEDICAL MANAGEMENT NEEDS.—An individual of any age who due to a physical cognitive or other mental impairment requires assistance to manage his or her medical or nursing care (as determined by the Secretary).

(5) YOUNG CHILDREN WITH SEVERE DISABILITIES.—An individual under 6 years of age who—

(A) has a severe disability or chronic medical condition that limits functioning in a manner that is comparable in severity to the standards established under paragraphs (1), (2), or (3); and

(B) is expected to have such a disability or condition for at least 180 days.

The Secretary shall elaborate the criteria for children under 6 years of age based on an analysis of Phase I (1994) and II (1996) of the National Disability Survey.

(6) STATE OPTION WITH RESPECT TO INDIVIDUALS WITH COMPARABLE DISABILITIES.—Not more than 5 percent of a State's allotment for services under this title may be expended for the provision of services to individuals with severe disabilities and long-term medical or nursing needs that are comparable in severity to the criteria described in para-

graphs (1) through (5), but who fail to meet the criteria in any single category under such paragraphs.

(b) DETERMINATION.—

(1) IN GENERAL.—In formulating eligibility criteria under subsection (a), the Secretary shall establish criteria for assessing the functional level of disability among all categories of individuals with disabilities that are comparable in severity, regardless of the age or the nature of the disabling condition of the individual. The determination of whether an individual is an individual with disabilities shall be made by a public or nonprofit agency that is specified under the State plan and that is not a provider of home and community-based services under this title and by using a uniform protocol consisting of an initial screening and a determination of disability specified by the Secretary. A State may not impose cost sharing with respect to a determination of disability. A State may collect additional information, at the time of obtaining information to make such determination, in order to provide for the assessment and plan described in section 104(b) or for other purposes.

(2) PERIODIC REASSESSMENT.—The determination that an individual is an individual with disabil-

ities shall be considered to be effective under the State plan for a period of not more than 6 months (or for such longer period in such cases as a significant change in an individual's condition that may affect such determination is unlikely). A reassessment shall be made if there is a significant change in an individual's condition that may affect such determination.

(c) ELIGIBILITY CRITERIA.—The Secretary shall reassess the validity of the eligibility criteria described in subsection (a) as new knowledge regarding the assessments of functional disabilities becomes available. The Secretary shall report to the Congress on its findings under the preceding sentence as determined appropriate by the Secretary.

(d) ACTIVITY OF DAILY LIVING DEFINED.—In this title, the term ''activity of daily living'' means any of the following: eating, toileting, dressing, bathing, and transferring.

(e) INDIVIDUALS WITH COGNITIVE OR OTHER MENTAL IMPAIRMENTS DEFINED.—In this title, the term ''individuals with cognitive or other mental impairments'' means an individual with Alzheimer's disease, dementia, autism, mental illness, mental retardation, congenital or

acquired brain injury, or any other severe mental condition.

SEC. 104. HOME AND COMMUNITY-BASED SERVICES COVERED UNDER STATE PLAN.

(a) SPECIFICATION.—

(1) IN GENERAL.—Subject to the succeeding provisions of this section, the State plan under this title shall specify—

(A) the home and community-based services available under the plan to individuals with disabilities (or to such categories of such individuals); and

(B) any limits with respect to such services.

(2) FLEXIBILITY IN MEETING INDIVIDUAL NEEDS.—Subject to subsection (e)(2), such services may be delivered in an individual's home, a range of community residential arrangements, or outside the home.

(b) REQUIREMENT FOR NEEDS ASSESSMENT AND PLAN OF CARE.—

(1) IN GENERAL.—The State plan shall provide for home and community-based services to an individual with disabilities only if the following requirements are met:

(A) COMPREHENSIVE ASSESSMENT.—

(i) IN GENERAL.—A comprehensive assessment of an individual's need for home and community-based services (regardless of whether all needed services are available under the plan) shall be made in accordance with a uniform, comprehensive assessment tool that shall be used by a State under this paragraph with the approval of the Secretary. The comprehensive assessment shall be made by a public or nonprofit agency that is specified under the State plan and that is not a provider of home and community-based services under this title.

(ii) EXCEPTION.—The State may elect to waive the provisions of clause (i) if—

(I) with respect to any area of the State, the State has determined that there is an insufficient pool of entities willing to perform comprehensive assessments in such area due to a low population of individuals eligible for home and community-based serv-

ices under this title residing in the area; and

(II) the State plan specifies procedures that the State will implement in order to avoid conflicts of interest.

(B) INDIVIDUALIZED PLAN OF CARE.—

(i) IN GENERAL.—An individualized plan of care based on the assessment made under subparagraph (A) shall be developed by a public or nonprofit agency that is specified under the State plan and that is not a provider of home and community-based services under this title, except that the State may elect to waive the provisions of this sentence if, with respect to any area of the State, the State has determined there is an insufficient pool of entities willing to develop individualized plans of care in such area due to a low population of individuals eligible for home and community-based services under this title residing in the area, and the State plan specifies procedures that the State will implement in order to avoid conflicts of interest.

(ii) REQUIREMENTS WITH RESPECT TO PLAN OF CARE.—A plan of care under this subparagraph shall—

(I) specify which services included under the individual plan will be provided under the State plan under this title;

(II) identify (to the extent possible) how the individual will be provided any services specified under the plan of care and not provided under the State plan;

(III) specify how the provision of services to the individual under the plan will be coordinated with the provision of other health care services to the individual; and

(IV) be reviewed and updated every 6 months (or more frequently if there is a change in the individual's condition).

The State shall make reasonable efforts to identify and arrange for services described in subclause (II). Nothing in this subsection shall be construed as requiring a

State (under the State plan or otherwise) to provide all the services specified in such a plan.

(C) INVOLVEMENT OF INDIVIDUALS.—The individualized plan of care under subparagraph (B) for an individual with disabilities shall—

(i) be developed by qualified individuals (specified in subparagraph (B));

(ii) be developed and implemented in close consultation with the individual (or the individual's designated representative); and

(iii) be approved by the individual (or the individual's designated representative).

(c) REQUIREMENT FOR CARE MANAGEMENT.—

(1) IN GENERAL.—The State shall make available to each category of individuals with disabilities care management services that at a minimum include—

(A) arrangements for the provision of such services; and

(B) monitoring of the delivery of services.

(2) CARE MANAGEMENT SERVICES.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the care management serv-

ices described in paragraph (1) shall be provided by a public or private entity that is not providing home and community-based services under this title.

(B) EXCEPTION.—A person who provides home and community-based services under this title may provide care management services if—

(i) the State determines that there is an insufficient pool of entities willing to provide such services in an area due to a low population of individuals eligible for home and community-based services under this title residing in such area; and

(ii) the State plan specifies procedures that the State will implement in order to avoid conflicts of interest.

(d) MANDATORY COVERAGE OF PERSONAL ASSISTANCE SERVICES.—The State plan shall include, in the array of services made available to each category of individuals with disabilities, both agency-administered and consumer-directed personal assistance services (as defined in subsection (h)).

(e) ADDITIONAL SERVICES.—

(1) TYPES OF SERVICES.—Subject to subsection (f), services available under a State plan under this title may include any (or all) of the following:

(A) Homemaker and chore assistance.

(B) Home modifications.

(C) Respite services.

(D) Assistive technology devices, as defined in section 3(2) of the Technology-Related Assistance for Individuals With Disabilities Act of 1988 (29 U.S.C. 2202(2)).

(E) Adult day services.

(F) Habilitation and rehabilitation.

(G) Supported employment.

(H) Home health services.

(I) Transportation.

(J) Any other care or assistive services specified by the State and approved by the Secretary that will help individuals with disabilities to remain in their homes and communities.

(2) CRITERIA FOR SELECTION OF SERVICES.—The State electing services under paragraph (1) shall specify in the State plan—

(A) the methods and standards used to select the types, and the amount, duration, and scope, of services to be covered under the plan

and to be available to each category of individuals with disabilities; and

(B) how the types, and the amount, duration, and scope, of services specified, within the limits of available funding, provide substantial assistance in living independently to individuals within each of the categories of individuals with disabilities.

(f) EXCLUSIONS AND LIMITATIONS.—A State plan may not provide for coverage of—

(1) room and board;

(2) services furnished in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other institutional setting specified by the Secretary; or

(3) items and services to the extent coverage is provided for the individual under a health plan or the medicare program.

(g) PAYMENT FOR SERVICES.—In order to pay for covered services, a State plan may provide for the use of—

(1) vouchers;

(2) cash payments directly to individuals with disabilities;

(3) capitation payments to health plans; and

(4) payment to providers.

(h) PERSONAL ASSISTANCE SERVICES.—

(1) IN GENERAL.—For purposes of this title, the term ''personal assistance services'' means those services specified under the State plan as personal assistance services and shall include at least hands-on and standby assistance, supervision, cueing with activities of daily living, and such instrumental activities of daily living as deemed necessary or appropriate, whether agency-administered or consumer-directed (as defined in paragraph (2)). Such services shall include services that are determined to be necessary to help all categories of individuals with disabilities, regardless of the age of such individuals or the nature of the disabling conditions of such individuals.

(2) CONSUMER-DIRECTED.—For purposes of this title:

(A) IN GENERAL.—The term ''consumer-directed'' means, with reference to personal assistance services or the provider of such services, services that are provided by an individual who is selected and managed (and, at the option of the service recipient, trained) by the individual receiving the services.

(B) STATE RESPONSIBILITIES.—A State plan shall ensure that where services are provided in a consumer-directed manner, the State shall create or contract with an entity, other than the consumer or the individual provider, to—

(i) inform both recipients and providers of rights and responsibilities under all applicable Federal labor and tax law; and

(ii) assume responsibility for providing effective billing, payments for services, tax withholding, unemployment insurance, and workers' compensation coverage, and act as the employer of the home care provider.

(C) RIGHT OF CONSUMERS.—Notwithstanding the State responsibilities described in subparagraph (B), service recipients, and, where appropriate, their designated representative, shall retain the right to independently select, hire, terminate, and direct (including manage, train, schedule, and verify services provided) the work of a home care provider.

(3) AGENCY ADMINISTERED.—For purposes of this title, the term ''agency-administered'' means,

with respect to such services, services that are not consumer-directed.

SEC. 105. COST SHARING.

(a) NO COST SHARING FOR POOREST.—

(1) IN GENERAL.—The State plan may not impose any cost sharing for individuals with income (as determined under subsection (d)) less than 150 percent of the official poverty level applicable to a family of the size involved (referred to in paragraph (2)).

(2) OFFICIAL POVERTY LEVEL.—For purposes of paragraph (1), the term ''official poverty level applicable to a family of the size involved'' means, for a family for a year, the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)) applicable to a family of the size involved.

(b) SLIDING SCALE FOR REMAINDER.—The State plan may impose cost sharing for individuals not described in subsection (a) in such form and manner as the State determines is appropriate.

(c) RECOMMENDATION OF THE SECRETARY.—The Secretary shall make recommendations to the States as

to how to reduce cost-sharing for individuals with extraordinary out-of-pocket costs for whom the imposition of cost-sharing could jeopardize their ability to take advantage of the services offered under this title. The Secretary shall establish a methodology for reducing the cost-sharing burden for individuals with exceptionally high out-of-pocket costs under this title.

(d) DETERMINATION OF INCOME FOR PURPOSES OF COST SHARING.—The State plan shall specify the process to be used to determine the income of an individual with disabilities for purposes of this section. Such standards shall include a uniform Federal definition of income and any allowable deductions from income.

SEC. 106. QUALITY ASSURANCE AND SAFEGUARDS.

(a) QUALITY ASSURANCE.—

(1) IN GENERAL.—The State plan shall specify how the State will ensure and monitor the quality of services, including—

(A) safeguarding the health and safety of individuals with disabilities;

(B) setting the minimum standards for agency providers and how such standards will be enforced;

(C) setting the minimum competency requirements for agency provider employees who

provide direct services under this title and how the competency of such employees will be enforced;

(D) obtaining meaningful consumer input, including consumer surveys that measure the extent to which participants receive the services described in the plan of care and participant satisfaction with such services;

(E) establishing a process to receive, investigate, and resolve allegations of neglect or abuse;

(F) establishing optional training programs for individuals with disabilities in the use and direction of consumer directed providers of personal assistance services;

(G) establishing an appeals procedure for eligibility denials and a grievance procedure for disagreements with the terms of an individualized plan of care;

(H) providing for participation in quality assurance activities; and

(I) specifying the role of the Long-Term Care Ombudsman (under the Older Americans Act of 1965 (42 U.S.C. 3001 et seq.)) and the protection and advocacy system (established

under section 142 of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6042)) in assuring quality of services and protecting the rights of individuals with disabilities.

(2) ISSUANCE OF REGULATIONS.—Not later than 1 year after the date of enactment of this Act, the Secretary shall issue regulations implementing the quality provisions of this subsection.

(b) FEDERAL STANDARDS.—The State plan shall adhere to Federal quality standards in the following areas:

(1) Case review of a specified sample of client records.

(2) The mandatory reporting of abuse, neglect, or exploitation.

(3) The development of a registry of provider agencies or home care workers and consumer directed providers of personal assistance services against whom any complaints have been sustained, which shall be available to the public.

(4) Sanctions to be imposed on States or providers, including disqualification from the program, if minimum standards are not met.

(5) Surveys of client satisfaction.

(6) State optional training programs for informal caregivers.

(c) CLIENT ADVOCACY.—

(1) IN GENERAL.—The State plan shall provide that the State will expend the amount allocated under section 109(b)(2) for client advocacy activities. The State may use such funds to augment the budgets of the Long-Term Care Ombudsman (under the Older Americans Act of 1965 (42 U.S.C. 3001 et seq.) and the protection and advocacy system (established under section 142 of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6042)) or may establish a separate and independent client advocacy office in accordance with paragraph (2) to administer a new program designed to advocate for client rights.

(2) CLIENT ADVOCACY OFFICE.—

(A) IN GENERAL.—A client advocacy office established under this paragraph shall—

(i) identify, investigate, and resolve complaints that—

(I) are made by, or on behalf of, clients; and

(II) relate to action, inaction, or decisions, that may adversely affect

the health, safety, welfare, or rights of the clients (including the welfare and rights of the clients with respect to the appointment and activities of guardians and representative payees), of—

(aa) providers, or representatives of providers, of long-term care services;

(bb) public agencies; or

(cc) health and social service agencies;

(ii) provide services to assist the clients in protecting the health, safety, welfare, and rights of the clients;

(iii) inform the clients about means of obtaining services provided by providers or agencies described in clause (i)(II) or services described in clause (ii);

(iv) ensure that the clients have regular and timely access to the services provided through the office and that the clients and complainants receive timely responses from representatives of the office to complaints; and

(v) represent the interests of the clients before governmental agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the clients with regard to the provisions of this title.

(B) CONTRACTS AND ARRANGEMENTS.—

(i) IN GENERAL.—Except as provided in clause (ii), the State agency may establish and operate the office, and carry out the program, directly, or by contract or other arrangement with any public agency or nonprofit private organization.

(ii) LICENSING AND CERTIFICATION ORGANIZATIONS; ASSOCIATIONS.—The State agency may not enter into the contract or other arrangement described in clause (i) with an agency or organization that is responsible for licensing, certifying, or providing long-term care services in the State.

(d) SAFEGUARDS.—

(1) CONFIDENTIALITY.—The State plan shall provide safeguards that restrict the use or disclosure of information concerning applicants and bene-

ficiaries to purposes directly connected with the administration of the plan.

(2) SAFEGUARDS AGAINST ABUSE.—The State plans shall provide safeguards against physical, emotional, or financial abuse or exploitation (specifically including appropriate safeguards in cases where payment for program benefits is made by cash payments or vouchers given directly to individuals with disabilities). All providers of services shall be required to register with the State agency.

(3) REGULATIONS.—Not later than October 1, 1998, the Secretary shall promulgate regulations with respect to the requirements on States under this subsection.

(e) SPECIFIED RIGHTS.—The State plan shall provide that in furnishing home and community-based services under the plan the following individual rights are protected:

(1) The right to be fully informed in advance, orally and in writing, of the care to be provided, to be fully informed in advance of any changes in care to be provided, and (except with respect to an individual determined incompetent) to participate in planning care or changes in care.

(2) The right to—

(A) voice grievances with respect to services that are (or fail to be) furnished without discrimination or reprisal for voicing grievances;

(B) be told how to complain to State and local authorities; and

(C) prompt resolution of any grievances or complaints.

(3) The right to confidentiality of personal and clinical records and the right to have access to such records.

(4) The right to privacy and to have one's property treated with respect.

(5) The right to refuse all or part of any care and to be informed of the likely consequences of such refusal.

(6) The right to education or training for oneself and for members of one's family or household on the management of care.

(7) The right to be free from physical or mental abuse, corporal punishment, and any physical or chemical restraints imposed for purposes of discipline or convenience and not included in an individual's plan of care.

(8) The right to be fully informed orally and in writing of the individual's rights.

(9) The right to a free choice of providers.

(10) The right to direct provider activities when an individual is competent and willing to direct such activities.

SEC. 107. ADVISORY GROUPS.

(a) FEDERAL ADVISORY GROUP.—

(1) ESTABLISHMENT.—The Secretary shall establish an advisory group, to advise the Secretary and States on all aspects of the program under this title.

(2) COMPOSITION.—The group shall be composed of individuals with disabilities and their representatives, providers, Federal and State officials, and local community implementing agencies. A majority of its members shall be individuals with disabilities and their representatives.

(b) STATE ADVISORY GROUPS.—

(1) IN GENERAL.—Each State plan shall provide for the establishment and maintenance of an advisory group to advise the State on all aspects of the State plan under this title.

(2) COMPOSITION.—Members of each advisory group shall be appointed by the Governor (or other chief executive officer of the State) and shall include individuals with disabilities and their representa-

tives, providers, State officials, and local community implementing agencies. A majority of its members shall be individuals with disabilities and their representatives. The members of the advisory group shall be selected from those nominated as described in paragraph (3).

(3) SELECTION OF MEMBERS.—Each State shall establish a process whereby all residents of the State, including individuals with disabilities and their representatives, shall be given the opportunity to nominate members to the advisory group.

(4) PARTICULAR CONCERNS.—Each advisory group shall—

(A) before the State plan is developed, advise the State on guiding principles and values, policy directions, and specific components of the plan;

(B) meet regularly with State officials involved in developing the plan, during the development phase, to review and comment on all aspects of the plan;

(C) participate in the public hearings to help assure that public comments are addressed to the extent practicable;

(D) report to the Governor and make available to the public any differences between the group's recommendations and the plan;

(E) report to the Governor and make available to the public specifically the degree to which the plan is consumer-directed; and

(F) meet regularly with officials of the designated State agency (or agencies) to provide advice on all aspects of implementation and evaluation of the plan.

SEC. 108. PAYMENTS TO STATES.

(a) IN GENERAL.—Subject to section 102(a)(9)(C) (relating to limitation on payment for administrative costs), the Secretary, in accordance with the Cash Management Improvement Act of 1990 (31 U.S.C. 6501 note), shall authorize payment to each State with a plan approved under this title, for each quarter (beginning on or after October 1, 1998), from its allotment under section 109(b), an amount equal to—

(1)(A) with respect to the amount demonstrated by State claims to have been expended during the year for home and community-based services under the plan for individuals with disabilities that does not exceed 20 percent of the amount allotted to the

State under section 109(b), 100 percent of such amount; and

(B) with respect to the amount demonstrated by State claims to have been expended during the year for home and community-based services under the plan for individuals with disabilities that exceeds 20 percent of the amount allotted to the State under section 109(b), the Federal home and community-based services matching percentage (as defined in subsection (b)) of such amount; plus

(2) an amount equal to 90 percent of the amount demonstrated by the State to have been expended during the quarter for quality assurance activities under the plan; plus

(3) an amount equal to 90 percent of the amount expended during the quarter under the plan for activities (including preliminary screening) relating to determinations of eligibility and performance of needs assessment; plus

(4) an amount equal to 90 percent (or, beginning with quarters in fiscal year 2007, 75 percent) of the amount expended during the quarter for the design, development, and installation of mechanical claims processing systems and for information retrieval; plus

(5) an amount equal to 50 percent of the remainder of the amounts expended during the quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b) FEDERAL HOME AND COMMUNITY-BASED SERVICES MATCHING PERCENTAGE.—In subsection (a), the term ''Federal home and community-based services matching percentage'' means, with respect to a State, the State's Federal medical assistance percentage (as defined in section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b))) increased by 15 percentage points, except that the Federal home and community-based services matching percentage shall in no case be more than 95 percent.

(c) PAYMENTS ON ESTIMATES WITH RETROSPECTIVE ADJUSTMENTS.—The method of computing and making payments under this section shall be as follows:

(1) The Secretary shall, prior to the beginning of each quarter, estimate the amount to be paid to the State under subsection (a) for such quarter, based on a report filed by the State containing its estimate of the total sum to be expended in such quarter, and such other information as the Secretary may find necessary.

(2) From the allotment available therefore, the Secretary shall provide for payment of the amount

so estimated, reduced or increased, as the case may be, by any sum (not previously adjusted under this section) by which the Secretary finds that the estimate of the amount to be paid the State for any prior period under this section was greater or less than the amount that should have been paid.

(d) APPLICATION OF RULES REGARDING LIMITATIONS ON PROVIDER-RELATED DONATIONS AND HEALTH CARE-RELATED TAXES.—The provisions of section 1903(w) of the Social Security Act (42 U.S.C. 1396b(w)) shall apply to payments to States under this section in the same manner as they apply to payments to States under section 1903(a) of such Act (42 U.S.C. 1396b(a)).

(e) FAILURE TO COMPLY WITH STATE PLAN.—If a State furnishing home and community-based services under this title fails to comply with the State plan approved under this title, the Secretary may either reduce the Federal matching rates available to the State under subsection (a) or withhold an amount of funds determined appropriate by the Secretary from any payment to the State under this section.

SEC. 109. APPROPRIATIONS; ALLOTMENTS TO STATES.

(a) APPROPRIATIONS.—

(1) FISCAL YEARS 1999 THROUGH 2007.—Subject to paragraph (5)(C), for purposes of this title,

the appropriation authorized under this title for each of fiscal years 1999 through 2007 is the following:

(A) For fiscal year 1999, $500,000,000.

(B) For fiscal year 2000, $750,000,000.

(C) For fiscal year 2001, $1,000,000,000.

(D) For fiscal year 2002, $1,500,000,000.

(E) For fiscal year 2003, $2,000,000,000.

(F) For fiscal year 2004, $2,500,000,000.

(G) For fiscal year 2005, $3,250,000,000.

(H) For fiscal year 2006, $4,000,000,000.

(I) For fiscal year 2007, $5,000,000,000.

(2) SUBSEQUENT FISCAL YEARS.—For purposes of this title, the appropriation authorized for State plans under this title for each fiscal year after fiscal year 2007 is the appropriation authorized under this subsection for the preceding fiscal year multiplied by—

(A) a factor (described in paragraph (3)) reflecting the change in the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics for the fiscal year; and

(B) a factor (described in paragraph (4)) reflecting the change in the number of individuals with disabilities for the fiscal year.

(3) CPI MEDICAL CARE EXPENDITURE INCREASE FACTOR.—For purposes of paragraph (2)(A), the factor described in this paragraph for a fiscal year is the ratio of—

(A) the percentage increase or decrease, respectively, in the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics, for the preceding fiscal year, to—

(B) such increase or decrease, as so measured, for the second preceding fiscal year.

(4) DISABLED POPULATION FACTOR.—For purposes of paragraph (2)(B), the factor described in this paragraph for a fiscal year is 100 percent plus (or minus) the percentage increase (or decrease) change in the disabled population of the United States (as determined for purposes of the most recent update under subsection (b)(3)(D)).

(5) LEGISLATIVE PROPOSAL FOR ADDITIONAL FUNDS DUE TO MEDICAID OFFSETS.—

(A) IN GENERAL.—Not later than January 1, 1998, the Secretary shall submit to the appropriate committees of Congress a legislative proposal that, during the period beginning on October 1, 1998, and ending on September 30, 2007, for each fiscal year during such period, allocates among the States with plans approved under this title an amount equal to 75 percent of the Federal medicaid long-term care savings. The legislative proposal shall provide that funds shall be allocated to such States without requiring any State matching payments in order to receive such funds.

(B) FEDERAL MEDICAID LONG-TERM CARE SAVINGS DEFINED.—In subparagraph (A), the term 'Federal medicaid long-term care savings' means with respect to a fiscal year, the amount equal to the amount of Federal outlays that would have been made under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) during such fiscal year but for the provision of home and community-based services under the program under this title.

(b) ALLOTMENTS TO STATES.—

(1) IN GENERAL.—The Secretary shall allot the amounts available under the appropriation authorized for the fiscal year under paragraph (1) of subsection (a), to the States with plans approved under this title in accordance with an allocation formula developed by the Secretary that takes into account—

(A) the percentage of the total number of individuals with disabilities in all States that reside in a particular State;

(B) the per capita costs of furnishing home and community-based services to individuals with disabilities in the State; and

(C) the percentage of all individuals with incomes at or below 150 percent of the official poverty line (as described in section 105(a)(2)) in all States that reside in a particular State.

(2) ALLOCATION FOR CLIENT ADVOCACY ACTIVITIES.—Each State with a plan approved under this title shall allocate ½ of 1 percent of the State's total allotment under paragraph (1) for client advocacy activities as described in section 106(c).

(3) NO DUPLICATE PAYMENT.—No payment may be made to a State under this section for any services provided to an individual to the extent that the State received payment for such services under

section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)).

(4) REALLOCATIONS.—Any amounts allotted to States under this subsection for a year that are not expended in such year shall remain available for State programs under this title and may be reallocated to States as the Secretary determines appropriate.

(c) STATE ENTITLEMENT.—This title constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal Government to provide for the payment to States of amounts described in subsection (a).

SEC. 110. FEDERAL EVALUATIONS.

Not later than December 31, 2004, December 31, 2007, and each December 31 thereafter, the Secretary shall provide to Congress analytical reports that evaluate—

(1) the extent to which individuals with low incomes and disabilities are equitably served;

(2) the adequacy and equity of service plans to individuals with similar levels of disability across States;

(3) the comparability of program participation across States, described by level and type of disability; and

(4) the ability of service providers to sufficiently meet the demand for services.

SEC. 111. INFORMATION AND TECHNICAL ASSISTANCE GRANTS RELATING TO DEVELOPMENT OF HOSPITAL LINKAGE PROGRAMS.

(a) FINDINGS.—Congress finds that—

(1) demonstration programs and projects have been developed to offer care management to hospitalized individuals awaiting discharge who are in need of long-term health care services that meet individual needs and preferences in home and community-based settings as an alternative to long-term nursing home care or institutional placement; and

(2) there is a need to disseminate information and technical assistance to hospitals and State and local community organizations regarding such programs and projects and to provide incentive grants to State and local public and private agencies, including area agencies on aging, to establish and expand programs that offer care management to individuals awaiting discharge from acute care hospitals who are in need of long-term care so that services

to meet individual needs and preferences can be arranged in home and community-based settings as an alternative to long-term placement in nursing homes or other institutional settings.

(b) DISSEMINATION OF INFORMATION, TECHNICAL ASSISTANCE, AND INCENTIVE GRANTS TO ASSIST IN THE DEVELOPMENT OF HOSPITAL LINKAGE PROGRAMS.—Part C of title III of the Public Health Service Act (42 U.S.C. 248 et seq.) is amended by adding at the end the following:

"SEC. 327B. DISSEMINATION OF INFORMATION, TECHNICAL ASSISTANCE AND INCENTIVE GRANTS TO ASSIST IN THE DEVELOPMENT OF HOSPITAL LINKAGE PROGRAMS.

''(a) DISSEMINATION OF INFORMATION.—The Secretary shall compile, evaluate, publish, and disseminate to appropriate State and local officials and to private organizations and agencies that provide services to individuals in need of long-term health care services, such information and materials as may assist such entities in replicating successful programs that are aimed at offering care management to hospitalized individuals who are in need of long-term care so that services to meet individual needs and preferences can be arranged in home and community-based settings as an alternative to long-term nursing home

placement. The Secretary may provide technical assistance to entities seeking to replicate such programs.

''(b) INCENTIVE GRANTS TO ASSIST IN THE DEVELOPMENT OF HOSPITAL LINKAGE PROGRAMS.—The Secretary shall establish a program under which incentive grants may be awarded to assist private and public agencies, including area agencies on aging, and organizations in developing and expanding programs and projects that facilitate the discharge of individuals in hospitals or other acute care facilities who are in need of long-term care services and placement of such individuals into home and community-based settings.

''(c) ADMINISTRATIVE PROVISIONS.—

''(1) ELIGIBLE ENTITIES.—To be eligible to receive a grant under subsection (b) an entity shall be—

''(A)(i) a State agency as defined in section 102(43) of the Older Americans Act of 1965 (42 U.S.C. 3002(43)); or

''(ii) a State agency responsible for administering home and community care programs under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.); or

"(B) if no State agency described in subparagraph (A) applies with respect to a particular State, a public or nonprofit private entity.

"(2) APPLICATIONS.—To be eligible to receive an incentive grant under subsection (b), an entity shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including—

"(A) an assessment of the need within the community to be served for the establishment or expansion of a program to facilitate the discharge of individuals in need of long-term care who are in hospitals or other acute care facilities into home and community-care programs that provide individually planned, flexible services that reflect individual choice or preference rather than nursing home or institutional settings;

"(B) a plan for establishing or expanding a program for identifying individuals in hospital or acute care facilities who are in need of individualized long-term care provided in home and community-based settings rather than nursing homes or other institutional settings and under-

taking the planning and management of individualized care plans to facilitate discharge into such settings;

"(C) assurances that nongovernmental case management agencies funded under grants awarded under this section are not direct providers of home and community-based services;

"(D) satisfactory assurances that adequate home and community-based long term care services are available, or will be made available, within the community to be served so that individuals being discharged from hospitals or acute care facilities under the proposed program can be served in such home and community-based settings, with flexible, individualized care that reflects individual choice and preference;

"(E) a description of the manner in which the program to be administered with amounts received under the grant will be continued after the termination of the grant for which such application is submitted; and

"(F) a description of any waivers or approvals necessary to expand the number of individuals served in federally funded home and community-based long term care programs in

order to provide satisfactory assurances that adequate home and community-based long term care services are available in the community to be served.

''(3) AWARDING OF GRANTS.—

''(A) PREFERENCES.—In awarding grants under subsection (b), the Secretary shall give preference to entities submitting applications that—

''(i) demonstrate an ability to coordinate activities funded using amounts received under the grant with programs providing individualized home and community-based case management and services to individuals in need of long term care with hospital discharge planning programs; and

''(ii) demonstrate that adequate home and community-based long term care management and services are available, or will be made available to individuals being served under the program funded with amounts received under subsection (b).

''(B) DISTRIBUTION.—In awarding grants under subsection (b), the Secretary shall ensure that such grants—

''(i) are equitably distributed on a geographic basis;

''(ii) include projects operating in urban areas and projects operating in rural areas; and

''(iii) are awarded for the expansion of existing hospital linkage programs as well as the establishment of new programs.

''(C) EXPEDITED CONSIDERATION.—The Secretary shall provide for the expedited consideration of any waiver application that is necessary under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) to enable an applicant for a grant under subsection (b) to satisfy the assurance required under paragraph (1)(D).

''(4) USE OF GRANTS.—An entity that receives amounts under a grant under subsection (b) may use such amounts for planning, development and evaluation services and to provide reimbursements for the costs of one or more case mangers to be located in or assigned to selected hospitals who would—

''(A) identify patients in need of individualized care in home and community-based long-term care;

''(B) assess and develop care plans in cooperation with the hospital discharge planning staff; and

''(C) arrange for the provision of community care either immediately upon discharge from the hospital or after any short term nursing-home stay that is needed for recuperation or rehabilitation;

''(5) DIRECT SERVICES SUBJECT TO REIMBURSEMENTS.—None of the amounts provided under a grant under this section may be used to provide direct services, other than case management, for which reimbursements are otherwise available under title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq. and 1396 et seq.).

''(6) LIMITATIONS.—

''(A) TERM.—Grants awarded under this section shall be for terms of less than 3 years.

''(B) AMOUNT.—Grants awarded to an entity under this section shall not exceed $300,000 per year. The Secretary may waive the limitation under this subparagraph where an applicant demonstrates that the number of hospitals or individuals to be served under the grant justifies such increased amounts.

''(C) SUPPLANTING OF FUNDS.—Amounts awarded under a grant under this section may not be used to supplant existing State funds that are provided to support hospital link programs.

''(d) EVALUATION AND REPORTS.—

''(1) BY GRANTEES.—An entity that receives a grant under this section shall evaluate the effectiveness of the services provided under the grant in facilitating the placement of individuals being discharged from hospitals or acute care facilities into home and community-based long term care settings rather than nursing homes. Such entity shall prepare and submit to the Secretary a report containing such information and data concerning the activities funded under the grant as the Secretary determines appropriate.

''(2) BY SECRETARY.—Not later than the end of the third fiscal year for which funds are appropriated under subsection (e), the Secretary shall prepare and submit to the appropriate committees of Congress, a report concerning the results of the evaluations and reports conducted and prepared under paragraph (1).

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $5,000,000 for each of the fiscal years 1998 through 2000.''.

TITLE II—PROSPECTIVE PAYMENT SYSTEM FOR NURSING FACILITIES

SEC. 201. DEFINITIONS.

In this title:

(1) ACUITY PAYMENT.—The term ''acuity payment'' means a fixed amount that will be added to the facility-specific prices for certain resident classes designated by the Secretary as requiring heavy care.

(2) AGGREGATED RESIDENT INVOICE.—The term ''aggregated resident invoice'' means a compilation of the per resident invoices of a nursing facility which contain the number of resident days for each resident and the resident class of each resident at the nursing facility during a particular month.

(3) ALLOWABLE COSTS.—The term ''allowable costs'' means costs which HCFA has determined to be necessary for a nursing facility to incur according to the Provider Reimbursement Manual (in this title referred to as ''HCFA-Pub. 15'').

(4) BASE YEAR.—The term ''base year'' means the most recent cost reporting period (consisting of a period which is 12 months in length, except for facilities with new owners, in which case the period is not less than 4 months and not more than 13 months) for which cost data of nursing facilities is available to be used for the determination of a prospective rate.

(5) CASE MIX WEIGHT.—The term ''case mix weight'' means the total case mix score of a facility calculated by multiplying the resident days in each resident class by the relative weight assigned to each resident class, and summing the resulting products across all resident classes.

(6) COMPLEX MEDICAL EQUIPMENT.—The term ''complex medical equipment'' means items such as ventilators, intermittent positive pressure breathing machines, nebulizers, suction pumps, continuous positive airway pressure devices, and bead beds such as air fluidized beds.

(7) DISTINCT PART NURSING FACILITY.—The term ''distinct part nursing facility'' means an institution which has a distinct part that is certified under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and meets the requirements of

section 201.1 of the Skilled Nursing Facility Manual published by HCFA (in this title referred to as ''HCFA-Pub. 12'').

(8) EFFICIENCY INCENTIVE.—The term ''efficiency incentive'' means a payment made to a nursing facility in recognition of incurring costs below a prespecified level.

(9) FIXED EQUIPMENT.—The term ''fixed equipment'' means equipment which meets the definition of building equipment in section 104.3 of HCFA-Pub. 15, including attachments to buildings such as wiring, electrical fixtures, plumbing, elevators, heating systems, and air conditioning systems.

(10) GEOGRAPHIC CEILING.—The term ''geographic ceiling'' means a limitation on payments in any given cost center for nursing facilities in 1 of no fewer than 8 geographic regions, further subdivided into rural and urban areas, as designated by the Secretary.

(11) HCFA.—The term ''HCFA'' means the Health Care Financing Administration.

(12) HEAVY CARE.—The term ''heavy care'' means an exceptionally high level of care which the

Secretary has determined is required for residents in certain resident classes.

(13) INDEXED FORWARD.—The term ''indexed forward'' means an adjustment made to a per diem rate to account for cost increases due to inflation or other factors during an intervening period following the base year and projecting such cost increases for a future period in which the rate applies. Indexing forward under this title shall be determined from the midpoint of the base year to the midpoint of the rate year.

(14) MDS.—The term ''MDS'' means a resident assessment instrument, currently recognized by HCFA, any extensions to MDS, and any extensions to accommodate subacute care which contain an appropriate core of assessment items with definitions and coding categories needed to comprehensively assess a nursing facility resident.

(15) MAJOR MOVABLE EQUIPMENT.—The term ''major movable equipment'' means equipment that meets the definition of major movable equipment in section 104.4 of HCFA-Pub. 15.

(16) NURSING FACILITY.—The term ''nursing facility'' means an institution that meets the requirements of a ''skilled nursing facility'' under section

1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a)) and of a ''nursing facility'' under section 1919(a) of that Act (42 U.S.C. 1396r(a)).

(17) PER BED LIMIT.—The term ''per bed limit'' means a per-bed ceiling on the fair asset value of a nursing facility for 1 of the geographic regions designated by the Secretary.

(18) PER DIEM RATE.—The term ''per diem rate'' refers to a rate of payment for the costs of covered services for a resident day.

(19) RELATIVE WEIGHT.—The term ''relative weight'' means the index of the value of the resources required for a given resident class relative to the value of resources of either a base resident class or the average of all the resident classes.

(20) R.S. MEANS INDEX.—The term ''R.S. Means Index'' means the index of the R. S. Means Company, Inc., specific to commercial or industrial institutionalized nursing facilities, that is based upon a survey of prices of common building materials and wage rates for nursing facility construction.

(21) REBASE.—The term ''rebase'' means the process of updating nursing facility cost data for a subsequent rate year using a more recent base year.

(22) RENTAL RATE.—The term ''rental rate'' means a percentage that will be multiplied by the fair asset value of property to determine the total annual rental payment in lieu of property costs.

(23) RESIDENT CLASSIFICATION SYSTEM.—The term ''resident classification system'' means a system that categorizes residents into different resident classes according to similarity of their assessed condition and required services of the residents.

(24) RESIDENT DAY.—The term ''resident day'' means the period of services for 1 resident, regardless of payment source, for 1 continuous 24 hours of services. The day of admission of the resident constitutes a resident day but the day of discharge does not constitute a resident day. Bed hold days are not to be considered resident days, and bed hold day revenues are not to be offset.

(25) RESOURCE UTILIZATION GROUPS, VERSION III.—The term ''Resource Utilization Groups, Version III'' (in this title referred to as ''RUG–III'') refers to a category-based resident classification system used to classify nursing facility residents into mutually exclusive RUG–III groups. Residents in each RUG–III group utilize similar quantities and patterns of resources.

(26) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(27) SUBACUTE CARE.—The term ''subacute care'' means comprehensive inpatient care designed for an individual that has an acute illness, injury, or exacerbation of a disease process. The care is goal oriented treatment rendered immediately after, or instead of, acute hospitalization to treat 1 or more specific active complex medical conditions or to administer 1 or more technically complex treatments, in the context of a person's underlying long-term conditions and overall situation. In most cases, the individual's condition is such that the care does not depend heavily on high technology monitoring or complex diagnostic procedures. Subacute care requires the coordinated services of an interdisciplinary team including physicians, nurses, and other relevant professional disciplines, who are trained and knowledgeable to assess and manage these specific conditions and perform the necessary procedures. Subacute care is given as part of a specifically defined program, regardless of the site. Subacute care is generally more intensive than traditional nursing facility care and less than acute care. It requires frequent (daily to weekly) recurrent patient assessment

and review of the clinical course and treatment plan for a limited (several days to several months) time period, until the condition is stabilized or a predetermined treatment course is completed.

SEC. 202. PAYMENT OBJECTIVES.

Payment rates under the Prospective Payment System for nursing facilities shall reflect the following objectives:

(1) To maintain an equitable and fair balance between cost containment and quality of care in nursing facilities.

(2) To encourage nursing facilities to admit residents without regard to such residents' source of payment.

(3) To provide an incentive to nursing facilities to admit and provide care to persons in need of comparatively greater care, including those in need of subacute care.

(4) To maintain administrative simplicity, for both nursing facilities and the Secretary.

(5) To encourage investment in buildings and improvements to nursing facilities (capital formation) as necessary to maintain quality and access.

SEC. 203. POWERS AND DUTIES OF THE SECRETARY.

(a) RULES AND REGULATIONS.—The Secretary shall establish by regulation all rules and regulations necessary for implementation of this title. The rates determined under this title shall be determined in a budget neutral manner and shall reflect the objectives described in section 202 of this title.

(b) FILING REQUIREMENTS.—The Secretary may require that each nursing facility file such data, statistics, schedules, or information as required to enable the Secretary to implement this title.

SEC. 204. RELATIONSHIP TO TITLE XVIII OF THE SOCIAL SECURITY ACT.

(a) IN GENERAL.—No provision in this title shall replace, or otherwise affect, the skilled nursing facility benefit under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(b) PROVISIONS OF HCFA–15.—The provisions of HCFA-Pub. 15 shall apply to the determination of allowable costs under this title except to the extent that such provisions conflict with any other provision in this title.

SEC. 205. ESTABLISHMENT OF RESIDENT CLASSIFICATION SYSTEM.

(a) IN GENERAL.—

(1) ESTABLISHMENT.—The Secretary shall establish a resident classification system which shall

group residents into classes according to similarity of their assessed condition and required services.

(2) MODEL FOR SYSTEM.—The resident classification system shall be modelled after the RUG-III system and all updated versions of that system, and shall be expanded into subacute categories and costs of care.

(3) REFLECTIVE OF CERTAIN TIME AND COSTS.—The resident classification system shall reflect of the necessary professional and paraprofessional nursing staff time and costs required to address the care needs of nursing facility residents.

(b) RELATIVE WEIGHT FOR EACH RESIDENT CLASS.—

(1) IN GENERAL.—The Secretary shall assign a relative weight for each resident class based on the relative value of the resources required for each resident class. If the Secretary determines it to be appropriate, the assignment of relative weights for resident classes shall be developed for each geographic region as determined in accordance with subsection (c).

(2) UTILIZATION OF MDSS.—In assigning the relative weights of the resident classes in a geographic region, the Secretary shall utilize informa-

tion derived from the most recent MDSs of all the nursing facilities in a geographic region.

(3) RECALIBRATED EVERY 3 YEARS.—Every 3 years the Secretary shall recalibrate the relative weights of the resident classes in each geographic region based on any changes in the cost or amount of resources required for the care of a resident in the resident class.

(c) GEOGRAPHIC REGIONS; PEER GROUPINGS.—

(1) GEOGRAPHIC REGIONS.—The Secretary shall designate at least 3 geographic regions for the total United States. Within each geographic region, the Secretary shall take appropriate account of variations in cost between urban and rural areas.

(2) PEER GROUPING.—The Secretary shall ensure that there are no peer grouping of nursing facilities based on facility size or whether the nursing facilities are hospital-based or not.

SEC. 206. COST CENTERS FOR NURSING FACILITY PAYMENT.

(a) PAYMENT RATES.—Consistent with the objectives described in section 202 of this title, the Secretary shall determine payment rates for nursing facilities using the following cost/service groupings:

(1) The nursing service cost center shall include salaries and wages for the Director of Nursing, quality assurance nurses, registered nurses, licensed practical nurses, nurse aides (including wages related to initial and ongoing nurse aid training and other ongoing or periodic training costs incurred by nursing personnel), contract nursing, fringe benefits and payroll taxes associated therewith, medical records, and nursing supplies.

(2) The administrative and general cost center shall include all expenses (including salaries, benefits, and other costs) related to administration, plant operation, maintenance and repair, housekeeping, dietary (excluding raw food), central services and supply (excluding medical or nursing supplies), laundry, and social services, excluding overhead allocations to ancillary services.

(3) Ancillary services that are paid on a fee-for-service basis shall include physical therapy, occupational therapy, speech therapy, respiratory therapy, and hyperalimentation. The fee-for-service ancillary service payments under part A of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) shall not affect the reimbursement of ancillary services

under part B of title XVIII of that Act (42 U.S.C. 1395j et seq.).

(4) The cost center for selected ancillary services and other costs shall include drugs, raw food, IV therapy, x-ray services, laboratory services, property tax, property insurance, and all other costs not included in the other 4 cost-of-service groupings.

(5) The property cost center shall include depreciation on the buildings and fixed equipment, major movable equipment, motor vehicles, land improvements, amortization of leasehold improvements, lease acquisition costs, capital leases, interest on capital indebtedness, mortgage interest, lease costs, and equipment rental expense.

(b) PER DIEM RATE.—The Secretary shall pay nursing facilities a prospective, facility-specific, per diem rate based on the sum of the per diem rates established for the nursing service, administrative and general, and property cost centers.

(c) FACILITY-SPECIFIC PROSPECTIVE RATE.—The Secretary shall pay nursing facilities a facility-specific prospective rate for each unit of the fee-for-service ancillary services as determined in accordance with section 210 of this title.

(d) REIMBURSEMENT FOR SELECTIVE ANCILLARY SERVICES.—Nursing facilities shall be reimbursed by the Secretary for selected ancillary services and other costs on a retrospective basis in accordance with section 211 of this title.

SEC. 207. RESIDENT ASSESSMENT.

(a) IN GENERAL.—In order to be eligible for payments under this title, a nursing facility shall perform a resident assessment in accordance with section 1819(b)(3) of the Social Security Act (42 U.S.C. 1395i–3(b)(3)) within 14 days of admission of the resident and at such other times as required by that section.

(b) RESIDENT CLASS.—The resident assessment shall be used to determine the resident class of each resident in the nursing facility for purposes of determining the per diem rate for the nursing service cost center in accordance with section 208 of this title.

SEC. 208. THE PER DIEM RATE FOR NURSING SERVICE COSTS.

(a) IN GENERAL.—

(1) NURSING SERVICE COST CENTER RATE.—The Secretary shall calculate the nursing service cost center rate using a prospective, facility-specific per diem rate based on the nursing facility's case-

mix weight and nursing service costs during the base year.

(2) CASE-MIX WEIGHT.—For purposes of paragraph (1), the case-mix weight of a nursing facility shall be obtained by multiplying the number of resident days in each resident class at a nursing facility during the base year by the relative weight assigned to each resident class in the appropriate geographic region. Once this calculation is performed for each resident class in the nursing facility, the sum of these products shall constitute the case-mix weight for the nursing facility.

(3) FACILITY NURSING UNIT VALUE.—A facility nursing unit value for the nursing facility for the base year shall be obtained by dividing the nursing service costs for the base year, which shall be indexed forward from the midpoint of the base period to the midpoint of the rate period using the DRI McGraw-Hill HCFA Nursing Home Without Capital Market Basket, by the case-mix weight of the nursing facility for the base year.

(4) FACILITY-SPECIFIC NURSING SERVICES PRICE.—A facility-specific nursing services price for each resident class shall be obtained my multiplying the lower of the indexed facility unit value of the

nursing facility during the base year or the geographic ceiling, as determined in accordance with subsection (b), by the relative weight of the resident class.

(5) PATIENT CLASSIFICATIONS.—For patient classifications associated with the use of complex medical equipment and other specialized, noncustomary equipment (particularly subacute classifications), the Secretary shall provide for a daily allowance for such equipment based upon the amortized value of such equipment over the life of the equipment.

(6) SELECTED RESIDENT CLASSIFICATIONS.—For selected resident classifications (particularly subacute classifications) requiring additional or specialized medical administrative staff, the Secretary shall provide for a daily allowance to cover these costs.

(7) DESIGNATION OF CERTAIN RESIDENT CLASSES.—The Secretary shall designate certain resident classes, such as subacute resident classes, as requiring heavy care. An acuity payment of 3 percent of the facility-specific nursing services price shall be added to the facility-specific price for each

resident that the Secretary has designated as requiring heavy care.

(8) PER DIEM RATE.—The per diem rate for the nursing service cost center for each resident in a resident class shall constitute the facility-specific price, plus the acuity payment where appropriate.

(9) PER DIEM RATE REBASED ANNUALLY.—The Secretary shall annually rebate the per diem rate for the nursing service cost center, including the facility-specific price and the acuity payment.

(10) PAYMENT.—To determine the payment amount to a nursing facility for the nursing service cost center, the Secretary shall multiply the per diem rate (including the acuity payment) for a resident class by the number of resident days for each resident class based on aggregated resident invoices which each nursing facility shall submit on a monthly basis.

(b) GEOGRAPHIC CEILING.—

(1) FACILITY UNIT VALUE.—The facility unit value identified in subsection (a)(3) shall be subjected to geographic ceilings established for the geographic regions designated by the Secretary in section 205 of this title.

(2) DETERMINATION.—

(A) IN GENERAL.—The Secretary shall determine the geographic ceiling by creating an array of indexed facility unit values in a geographic region from lowest to highest. Based on this array, the Secretary shall identify a fixed proportion between the indexed facility unit value of the nursing facility which contained the medianth resident day in the array (except as provided in subsection (b)(4) of this section) and the indexed facility unit value of the nursing facility which contained the 95th percentile resident day in that array during the first year of operation of the Prospective Payment System for nursing facilities. The fixed proportion shall remain the same in subsequent years.

(B) SUBSEQUENT YEARS.—To obtain the geographic ceiling on the indexed facility unit value for nursing facilities in a geographic region in each subsequent year, the fixed proportion identified pursuant to subparagraph (A) shall be multiplied by the indexed facility unit value of the nursing facility which contained the medianth resident day in the array of facility unit values for the geographic region during the base year.

(3) EXCLUSIONS FROM DETERMINATION.—For purposes of determining the geographic ceiling for a nursing service cost center, the Secretary shall exclude low volume and new nursing facilities (as defined in section 214 of this title).

(c) EXCEPTIONS TO GEOGRAPHIC CEILING.—The Secretary shall establish by regulation procedures for allowing exceptions to the geographic ceiling imposed on a nursing service cost center. The procedure shall permit exceptions based on the following factors:

(1) Local supply or labor shortages which substantially increase costs to specific nursing facilities.

(2) Higher per resident day usage of contract nursing personnel, if utilization of contract nursing personnel is warranted by local circumstances and the provider has taken all reasonable measures to minimize contract personnel expense.

(3) Extraordinarily low proportion of distinct part nursing facilities in a geographic region resulting in a geographic ceiling that unfairly restricts the reimbursement of distinct part facilities.

(4) Regulatory changes that increase costs to only a subset of the nursing facility industry.

(5) The offering of a new institutional health service or treatment program by a nursing facility (in order to account for initial startup costs).

(6) Disproportionate usage of part-time employees, where adequate numbers of full-time employees cannot reasonably be obtained.

(7) Other cost producing factors specified by the Secretary in regulations that are specific to a subset of facilities in a geographic region (except case-mix variation).

SEC. 209. THE PER DIEM RATE FOR ADMINISTRATIVE AND GENERAL COSTS.

(a) IN GENERAL.—

(1) PAYMENT.—The Secretary shall make payments for the administrative and general cost center by using a facility-specific, prospective, per diem rate.

(2) STANDARDS FOR PER DIEM RATE.—The Secretary shall assign a per diem rate to a nursing facility by applying 2 standards that is calculated as follows:

(A) STANDARD A.—The Secretary shall determine a Standard A for each geographic region by creating an array of indexed nursing facility administrative and general per diem costs

from lowest to highest. The Secretary shall then identify a fixed proportion by dividing the indexed administrative and general per diem costs of the nursing facility that contains the medianth resident day of the array (except as provided in subsection (a)(4)) into the indexed administrative and general per diem costs of the nursing facility that contains the 75th percentile resident day in that array. Standard A for each base year shall constitute the product of this fixed proportion and the administrative and general indexed per diem costs of the nursing facility that contains the medianth resident day in the array of such costs during the base year.

(B) STANDARD B.—The Secretary shall determine a Standard B for each geographic region by using the same calculation as in subparagraph (A) except that the fixed proportion shall use the indexed administrative and general costs of the nursing facility containing the 85th percentile, rather than the 75th percentile, resident day in the array of such costs.

(3) GEOGRAPHIC REGIONS.—The Secretary shall use the geographic regions identified in section

205(c) of this title for purposes of determining Standards A and B.

(4) EXCLUSION.—The Secretary shall exclude low volume and new nursing facilities (as defined in section 214 of this title) for purposes of determining Standard A and Standard B.

(5) PER DIEM RATE.—To determine a nursing facility's per diem rate for the administrative and general cost center, Standards A and B shall be applied to a nursing facility's administrative and general per diem costs, indexed forward using the DRI McGraw-Hill HCFA Nursing Home Without Capital Market Basket, as follows:

(A) Each nursing facility having indexed costs which are below the median shall be assigned a rate equal to their individual indexed costs plus an ''efficiency incentive'' equal to ½ of the difference between the median and Standard A.

(B) Each nursing facility having indexed costs which are below Standard A but are equal to or exceed the median shall be assigned a per diem rate equal to their individual indexed costs plus an ''efficiency incentive'' equal to ½ of the

difference between the nursing facility's indexed costs and Standard A.

(C) Each nursing facility having indexed costs which are between Standard A and Standard B shall be assigned a rate equal to Standard A plus ½ of the difference between the nursing facility's indexed costs and Standard A.

(D) Each nursing facility having indexed costs which exceed Standard B shall be assigned a rate as if their costs equaled Standard B. These nursing facilities shall be assigned a per diem rate equal to Standard A plus ½ of the difference between Standard A and Standard B.

(E) For purposes of subparagraphs (A) through (D), the median represents the indexed administrative and general per diem costs of a nursing facility that contains the medianth resident day in the array of such costs during the base year in the geographic region.

(b) REBASING.—Not less than annually, the Secretary shall rebase the payment rates for administrative and general costs.

SEC. 210. PAYMENT FOR FEE-FOR-SERVICE ANCILLARY SERVICES.

(a) IN GENERAL.—The Secretary shall make payments for the ancillary services described in section 206(a)(3) on a prospective fee-for-service basis.

(b) PAYMENT METHODOLOGY.—The Secretary shall identify the fee for each of the fee-for-service ancillary services for a particular nursing facility by dividing the nursing facility's reasonable costs, including overhead allocated through the cost finding process, of providing each particular service, indexed forward using the DRI McGraw-Hill HCFA Nursing Home Without Capital Market Basket, by the units of the particular service provided by the nursing facility during the cost year.

(c) COMPUTATION PERIOD.—The fee for each of the fee-for-service ancillary services shall be calculated by the Secretary under this title at least once a year for each facility and ancillary service.

SEC. 211. REIMBURSEMENT OF SELECTED ANCILLARY SERVICES AND OTHER COSTS.

(a) IN GENERAL.—Reimbursement of selected ancillary services and other costs identified in section 206(a)(4) of this title shall be reimbursed by the Secretary on a retrospective basis as pass-through costs, including overhead allocated through the cost-finding process.

(b) CHARGE-BASED INTERIM RATES.—The Secretary shall set charge-based interim rates for selected ancillary services and other costs for each nursing facility providing such services. Any overpayments or underpayments resulting from the difference between the interim and final settlement rates shall be either refunded by the nursing facility or paid to the nursing facility following submission of a timely filed medicare cost report.

SEC. 212. PER DIEM PAYMENT FOR PROPERTY COSTS.

(a) IN GENERAL.—The Secretary shall make a per diem payment for property costs based on a gross rental system. The amount of the payment shall be determined as follows:

(1) BUILDING AND FIXED EQUIPMENT VALUE.—In the case of a new facility in any geographic region, the cost for building and fixed equipment used in determining the gross rental shall be equivalent to the median cost of home construction in the region (as measured by RS Means). Such cost shall then be multiplied by the factor 1.2 to account for land and the value of movable equipment. The resulting value shall be indexed each year using the RS Means Construction Cost Index.

(2) AGE.—

(A) IN GENERAL.—The gross rental system establishes a facility's value based on its age. The older the facility, the less its value. Additions, replacements, and renovations shall be recognized by lowering the age of the facility and, thus, increasing the facility's value. Existing facilities, 1 year or older, shall be valued at the new bed value less 2 percent per year according to the ''age'' of the facility. Facilities shall not be depreciated to an amount less than 50 percent of the new construction bed value.

(B) ADDITION OF BEDS.—The addition of beds shall require a computation by the Secretary of the weighted average age of the facility based on the construction dates of the original facility and the additions.

(C) REPLACEMENT OF BEDS.—The replacement of existing beds shall result in an adjustment to the age of the facility. A weighted average age shall be calculated by the Secretary according to the year of initial construction and the year of bed replacement. If a facility has a series of additions or replacements, the Secretary shall assume that the oldest beds are the

ones being replaced when computing the average facility age.

(D) RENOVATIONS OR MAJOR IMPROVEMENTS.—Renovations or major improvements shall be calculated by the Secretary as a bed replacement, except that the value of the bed prior to renovation shall be taken into consideration. To qualify as a bed replacement, the bed being renovated must be at least 10 years old and the renovation or improvements cost must be equal to or greater than the difference between the existing bed value and the value of a new bed. To determine the new adjusted facility age, the number of renovated beds assigned a ''new'' age is determined by dividing the total cost of renovation by the difference between the existing bed value and the value of the new bed.

(E) STARTUP OF GROSS RENTAL SYSTEM.—To start up the fair rental system, each facility's bed values shall be determined by the Secretary based on the age of the facility. The determination shall include setting a value for the original beds with adjustments for any additions, bed replacements, and major renovations. For determination of bed values for use in de-

termining the initial rate, the procedures described above for determining the values of original beds, additions, and replacements shall be used.

(3) TOTAL CURRENT VALUE.—The Secretary shall multiply the per bed value by the number of beds in the facility to estimate the facility's total current value.

(4) RENTAL FACTOR.—The Secretary shall apply a rental factor to the facility's total current value to estimate its annual gross rental value. The Secretary shall determine the rental factor by using the Treasury Bond Composite Yield (greater than 10 years) as published in the Federal Reserve Bulletin plus a risk premium. A risk premium in the amount of 3 percentage points shall be added to the Treasury Yield. The rental factor is multiplied by the facility's total value, as determined in paragraph (3), to determine the annual gross rental value.

(5) PER DIEM PROPERTY PAYMENT.—The annual gross rental value shall be divided by the Secretary by 90 percent of the facility's annual licensed bed days during the cost report period to arrive at the per diem property payment.

(6) PER RESIDENT DAY RENTAL RATE.—The per resident day rental rate for a newly constructed facility during its first year of operation shall be based on the total annual rental divided by the greater of 50 percent of available resident days or actual annualized resident days up to 90 percent of annual licensed bed days during the first year of operation.

(b) Facilities in operation prior to the effective date of this Act shall receive the per resident day rental or actual costs, as determined in accordance with HCFA-Pub. 15, whichever is greater, except that a nursing facility shall be reimbursed the per resident day rental on and after the earliest of the following dates:

(1) the date upon which the nursing facility changes ownership;

(2) the date the nursing facility accepts the per resident day rental; or

(3) the date of the renegotiation of the lease for the land or buildings, not including the exercise of optional extensions specifically included in the original lease agreement or valid extensions thereof.

SEC. 213. MID-YEAR RATE ADJUSTMENTS.

(a) MID-YEAR ADJUSTMENTS.—The Secretary shall establish by regulation a procedure for granting mid-year

rate adjustments for the nursing service, administrative and general, and fee-for-service ancillary services cost centers.

(b) INDUSTRY-WIDE BASIS.—The mid-year rate adjustment procedure shall require the Secretary to grant adjustments on an industry-wide basis, without the need for nursing facilities to apply for such adjustments, based on the following circumstances:

(1) Statutory or regulatory changes affecting nursing facilities.

(2) Changes to the Federal minimum wage.

(3) General labor shortages with high regional wage impacts.

(c) APPLICATION FOR ADJUSTMENT.—The mid-year rate adjustment procedure shall permit specific facilities or groups of facilities to apply to the Secretary for an adjustment based on the following factors:

(1) Local labor shortages.

(2) Regulatory changes that apply to only a subset of the nursing facility industry.

(3) Economic conditions created by natural disasters or other events outside of the control of the provider.

(4) Other cost producing factors, except case-mix variation, to be specified by the Secretary in regulations.

(d) REQUIREMENTS FOR APPLICATION FOR ADJUSTMENT.—

(1) IN GENERAL.—A nursing facility which applies for a mid-year rate adjustment pursuant to this section shall be required to show that the adjustment will result in a greater than 2 percent deviation in the per diem rate for any individual cost service center or a deviation of greater than $5,000 in the total projected and indexed costs for the rate year, whichever is less.

(2) COST EXPERIENCE DATA.—A nursing facility application for a mid-year rate adjustment must be accompanied by recent cost experience data and budget projections.

SEC. 214. EXCEPTION TO PAYMENT METHODS FOR NEW AND LOW VOLUME NURSING FACILITIES.

(a) DEFINITION OF LOW VOLUME NURSING FACILITY.—In this title, the term ''low volume nursing facility'' means a nursing facility having fewer than 2,500 medicare part A resident days per year.

(b) DEFINITION OF NEW NURSING FACILITY.—In this title, the term ''new nursing facility'' means a newly

constructed, licensed, and certified nursing facility or a nursing facility that is in its first 3 years of operation as a provider of services under part A of the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). A nursing facility that has operated for more than 3 years but has a change of ownership shall not constitute a new facility.

(c) OPTION FOR LOW VOLUME NURSING FACILITIES.—A Low volume nursing facility shall have the option of submitting a cost report to the Secretary to receive retrospective payment for all of the cost centers, other than the property cost center, or accepting a per diem rate which shall be based on the sum of—

(1) the median indexed resident day facility unit value for the appropriate geographic region for the nursing service cost center during the base year as identified in section 208(b)(2) of this title;

(2) the median indexed resident day administrative and general per diem costs of all nursing facilities in the appropriate geographic region as identified in section 209(a)(5)(E) of this title;

(3) the median indexed resident day costs per unit of service for fee-for-service ancillary services obtained using the cost information from the nursing facilities in the appropriate geographic region

during the base year, excluding low volume and new nursing facilities, and based on an array of such costs from lowest to highest; and

(4) the median indexed resident day per diem costs for selected ancillary services and other costs obtained using information from the nursing facilities in the appropriate geographic region during the base year, excluding low volume and new nursing facilities, and based on an array of such costs from lowest to highest.

(d) OPTION FOR NEW NURSING FACILITIES.—New nursing facilities shall have the option of being paid by the Secretary on a retrospective cost pass-through basis for all costs centers, or in accordance with subsection (c).

SEC. 215. APPEAL PROCEDURES.

(a) IN GENERAL.—

(1) APPEAL.—Any person or legal entity aggrieved by a decision of the Secretary under this title, and which results in an amount in controversy of $10,000 or more, shall have the right to appeal such decision directly to the Provider Reimbursement Review Board (in this section referred to as ''the Board'') authorized under section 1878 of the Social Security Act (42 U.S.C. 1395oo).

(2) AMOUNT IN CONTROVERSY.—The $10,000 amount in controversy referred to in paragraph (1) shall be computed in accordance with 42 C.F.R. 405.1839.

(b) HEARINGS.—Any appeals to and any hearings before the Board under this title shall follow the procedures under section 1878 of the Social Security Act (42 U.S.C. 1395oo) and the regulations contained in (42 C.F.R. 405.1841–1889), except to the extent that they conflict with, or are inapplicable on account of, any other provision of this title.

SEC. 216. TRANSITION PERIOD.

The Prospective Payment System described in this title shall be phased in over a 3 year period using the following blended rate:

(1) For the first year that the provisions of this title are in effect, 25 percent of the payment rates will be based on the Prospective Payment System under this title and 75 percent will remain based upon reasonable cost reimbursement.

(2) For the second year that the provisions of this title are in effect, 50 percent of the payment rates will be based on the Prospective Payment System under this title and 50 percent based upon reasonable cost reimbursement.

(3) For the third year that the provisions of this title are in effect, 75 percent of the payment rates will be based on the Prospective Payment System under this title and 25 percent based upon reasonable cost reimbursement.

(4) For the fourth year that the provisions of this title are in effect and for all subsequent years, the payment rates will be based solely on the Prospective Payment System under this title.

SEC. 217. EFFECTIVE DATE; INCONSISTENT PROVISIONS.

(a) EFFECTIVE DATE.—The provisions of this title shall take effect on October 1, 1998.

(b) INCONSISTENT PROVISIONS.—The provisions contained in this title shall supersede any other provisions of title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq. 1396 et seq.) which are inconsistent with such provisions.

TITLE III—ADDITIONAL MEDICARE PROVISIONS

SEC. 301. ELIMINATION OF FORMULA-DRIVEN OVERPAYMENTS FOR CERTAIN OUTPATIENT HOSPITAL SERVICES.

(a) AMBULATORY SURGICAL CENTER PROCEDURES.—Section 1833(i)(3)(B)(i)(II) of the Social Security Act (42 U.S.C. 1395l(i)(3)(B)(i)(II)) is amended—

(1) by striking ''of 80 percent''; and

(2) by striking the period at the end and inserting the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).''.

(b) RADIOLOGY SERVICES AND DIAGNOSTIC PROCEDURES.—Section 1833(n)(1)(B)(i)(II) of the Social Security Act (42 U.S.C. 1395l(n)(1)(B)(i)(II)) is amended—

(1) by striking ''of 80 percent''; and

(2) by striking the period at the end and inserting the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished during portions of cost reporting periods occurring on or after July 1, 1997.

SEC. 302. PERMANENT EXTENSION OF CERTAIN SECONDARY PAYER PROVISIONS.

(a) WORKING DISABLED.—Section 1862(b)(1)(B) of the Social Security Act (42 U.S.C. 1395y(b)(1)(B)) is amended by striking clause (iii).

(b) INDIVIDUALS WITH END STAGE RENAL DISEASE.—Section 1862(b)(1)(C) of the Social Security Act (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the first sentence, by striking ''12-month'' each place it appears and inserting ''18-month'', and

(2) by striking the second sentence.

(c) IRS–SSA–HCFA DATA MATCH.—

(1) SOCIAL SECURITY ACT.—Section 1862(b)(5)(C) of the Social Security Act (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) INTERNAL REVENUE CODE.—Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

SEC. 303. FINANCING AND QUALITY MODERNIZATION AND REFORM.

(a) PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.—Section 1876(a) of the Social Security Act (42 U.S.C. 1395mm(a)) is amended to read as follows:

''(a)(1)(A) The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) not later than October 1 before the calendar year concerned—

''(i) a per capita rate of payment for individuals who are enrolled under this section with an eligible organization which has entered into a risk-sharing

contract and who are entitled to benefits under part A and enrolled under part B, and

''(ii) a per capita rate of payment for individuals who are so enrolled with such an organization and who are enrolled under part B only.

For purposes of this section, the term 'risk-sharing contract' means a contract entered into under subsection (g) and the term 'reasonable cost reimbursement contract' means a contract entered into under subsection (h).

''(B)(i) The annual per capita rate of payment for each medicare payment area (as defined in paragraph (5)) shall be equal to 95 percent of the adjusted average per capita cost (as defined in paragraph (4)), adjusted by the Secretary for—

''(I) individuals who are enrolled under this section with an eligible organization which has entered into a risk-sharing contract and who are enrolled under part B only; and

''(II) such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate so as to ensure actuarial equivalence.

The Secretary may add to, modify, or substitute for such factors, if such changes will improve the determination of actuarial equivalence.

''(ii) The Secretary shall reduce the annual per capita rate of payment by a uniform percentage (determined by the Secretary for a year, subject to adjustment under subparagraph (G)(v)) so that the total reduction is estimated to equal the amount to be paid under subparagraph (G).

''(C) In the case of an eligible organization with a risk-sharing contract, the Secretary shall make monthly payments in advance and in accordance with the rate determined under subparagraph (B) and except as provided in subsection (g)(2), to the organization for each individual enrolled with the organization under this section.

''(D) The Secretary shall establish a separate rate of payment to an eligible organization with respect to any individual determined to have end-stage renal disease and enrolled with the organization. Such rate of payment shall be actuarially equivalent to rates paid to other enrollees in the payment area (or such other area as specified by the Secretary).

''(E)(i) The amount of payment under this paragraph may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled in the plan under this section and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

''(ii)(I) Subject to subclause (II), the Secretary may make retroactive adjustments under clause (i) to take into account individuals enrolled during the period beginning on the date on that the individual enrolls with an eligible organization (that has a risk-sharing contract under this section) under a health benefit plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the plan under this section, except that for purposes of making such retroactive adjustments under this clause, such period may not exceed 90 days.

''(II) No adjustment may be made under subclause (I) with respect to any individual who does not certify that the organization provided the individual with the explanation described in subsection (c)(3)(E) at the time the individual enrolled with the organization.

''(F)(i) At least 45 days before making the announcement under subparagraph (A) for a year, the Secretary shall provide for notice to eligible organizations of proposed changes to be made in the methodology or benefit coverage assumptions from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

''(ii) In each announcement made under subparagraph (A), the Secretary shall include an explanation of the assumptions (including any benefit coverage assumptions) and changes in methodology used in the announcement in sufficient detail so that eligible organizations can compute per capita rates of payment for individuals located in each county (or equivalent medicare payment area) which is in whole or in part within the service area of such an organization.

''(2) With respect to any eligible organization that has entered into a reasonable cost reimbursement contract, payments shall be made to such plan in accordance with subsection (h)(2) rather than paragraph (1).

''(3) Subject to subsection (c) (2)(B)(ii) and (7), payments under a contract to an eligible organization under paragraph (1) or (2) shall be instead of the amounts that (in the absence of the contract) would be otherwise payable, pursuant to sections 1814(b) and 1833(a), for services furnished by or through the organization to individuals enrolled with the organization under this section.

''(4)(A) For purposes of this section, the 'adjusted average per capita cost' for a medicare payment area (as defined in paragraph (5)) is equal to the greatest of the following:

''(i) The sum of—

"(I) the area-specific percentage for the year (as specified under subparagraph (B) for the year) of the area-specific adjusted average per capita cost for the year for the medicare payment area, as determined under subparagraph (C), and

"(II) the national percentage (as specified under subparagraph (B) for the year) of the input-price-adjusted national adjusted average per capita cost for the year, as determined under subparagraph (D),

multiplied by a budget neutrality adjustment factor determined under subparagraph (E).

"(ii) An amount equal to—

"(I) in the case of 1998, 85 percent of the average annual per capita cost under parts A and B of this title for 1997;

"(II) in the case of 1999, 85 percent of the average annual per capita cost under parts A and B of this title for 1998; and

"(III) in the case of a succeeding year, the amount specified in this clause for the preceding year increased by the national average per capita growth percentage specified under subparagraph (F) for that succeeding year.

''(B) For purposes of subparagraph (A)(i)—

''(i) for 1998, the 'area-specific percentage' is 75 percent and the 'national percentage' is 25 percent,

''(ii) for 1999, the 'area-specific percentage' is 60 percent and the 'national percentage' is 40 percent,

''(iii) for 2000, the 'area-specific percentage' is 40 percent and the 'national percentage' is 60 percent,

''(iv) for 2001, the 'area-specific percentage' is 25 percent and the 'national percentage' is 75 percent, and

''(v) for 2002 and each subsequent year, the 'area-specific percentage' is 10 percent and the 'national percentage' is 90 percent.

''(C) For purposes of subparagraph (A)(i), the area-specific adjusted average per capita cost for a medicare payment area—

''(i) for 1998, is the annual per capita rate of payment for 1997 for the medicare payment area (determined under this subsection, as in effect the day before the date of enactment of the Long-Term Care Reform and Deficit Reduction Act of 1997), increased by the national average per capita growth

percentage for 1998 (as defined in subparagraph (F)); or

''(ii) for a subsequent year, is the area-specific adjusted average per capita cost for the previous year determined under this subparagraph for the medicare payment area, increased by the national average per capita growth percentage for such subsequent year.

''(D)(i) For purposes of subparagraph (A)(i), the input-price-adjusted national adjusted average per capita cost for a medicare payment area for a year is equal to the sum, for all the types of medicare services (as classified by the Secretary), of the product (for each such type of service) of—

''(I) the national standardized adjusted average per capita cost (determined under clause (ii)) for the year,

''(II) the proportion of such rate for the year which is attributable to such type of services, and

''(III) an index that reflects (for that year and that type of services) the relative input price of such services in the area compared to the national average input price of such services.

In applying subclause (III), the Secretary shall, subject to clause (iii), apply those indices under this title that are

used in applying (or updating) national payment rates for specific areas and localities.

''(ii) In clause (i)(I), the 'national standardized adjusted average per capita cost' for a year is equal to—

''(I) the sum (for all medicare payment areas) of the product of (aa) the area-specific adjusted average per capita cost for that year for the area under subparagraph (C), and (bb) the average number of medicare beneficiaries residing in that area in the year; divided by

''(II) the total average number of medicare beneficiaries residing in all the medicare payment areas for that year.

''(iii) In applying this subparagraph for 1998—

''(I) medicare services shall be divided into 2 types of services: part A services and part B services;

''(II) the proportions described in clause (i)(II) for such types of services shall be—

''(aa) for part A services, the ratio (expressed as a percentage) of the average annual per capita rate of payment for the area for part A for 1997 to the total average annual per capita rate of payment for the area for parts A and B for 1997, and

"(bb) for part B services, 100 percent minus the ratio described in item (aa);

"(III) for part A services, 70 percent of payments attributable to such services shall be adjusted by the index used under section 1886(d)(3)(E) to adjust payment rates for relative hospital wage levels for hospitals located in the payment area involved;

"(IV) for part B services—

"(aa) 66 percent of payments attributable to such services shall be adjusted by the index of the geographic area factors under section 1848(e) used to adjust payment rates for physicians' services furnished in the payment area, and

"(bb) of the remaining 34 percent of the amount of such payments, 70 percent shall be adjusted by the index described in subclause (III); and

"(V) the index values shall be computed based only on the beneficiary population who are 65 years of age or older and are not determined to have end-stage renal disease.

The Secretary may continue to apply the rules described in this clause (or similar rules) for 1999.

''(E) For each year, the Secretary shall compute a budget neutrality adjustment factor so that the aggregate of the payments under this section shall not exceed the aggregate payments that would have been made under this section if the area-specific percentage for the year had been 100 percent and the national percentage had been 0 percent.

''(F) In this section, the 'national average per capita growth percentage' for a year is equal to the Secretary's estimate (after consultation with the Secretary of the Treasury) of the 3-year average (ending with the year involved) of the annual rate of growth in the national average wage index (as defined in section 209(k)(1)) for each year in the period.

''(5)(A) In this section the term 'medicare payment area' means a county, or equivalent area specified by the Secretary.

''(B) In the case of individuals who are determined to have end-stage renal disease, the medicare payment area shall be each State.

''(6) The payment to an eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A and enrolled under part B shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supple-

mentary Medical Insurance Trust Fund. The portion of that payment to the organization for a month to be paid by each trust fund shall be determined as follows:

''(A) In regard to expenditures by eligible organizations having risk-sharing contracts, the allocation shall be determined each year by the Secretary based on the relative weight that benefits from each fund contribute to the adjusted average per capita cost.

''(B) In regard to expenditures by eligible organizations operating under a reasonable cost reimbursement contract, the initial allocation shall be based on the plan's most recent budget, such allocation to be adjusted, as needed, after cost settlement to reflect the distribution of actual expenditures.

The remainder of that payment shall be paid by the former trust fund.

''(7) Subject to paragraphs (2)(B)(ii) and (7) of subsection (c), if an individual is enrolled under this section with an eligible organization having a risk-sharing contract, only the eligible organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.''.

(b) EFFECTIVE DATE.—The amendment made by this section takes effect on October 1, 1997.

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